13d. REHABILITATIVE SERVICES. The following services are considered rehabilitative services:

Outpatient mental health rehabilitative services meeting standards as determined by the South Carolina Department of Health and Human Services.

(Effective 7-1-88)

Alcohol and Drug Abuse Services that are ordered by a licensed physician and provided by, or under the direct supervision of, a credentialed professional in the alcohol and drug abuse field. Eligible providers must be facilities licensed by the South Carolina Department of Health and Environmental Control as an outpatient facility for chemically dependent or addicted persons, and meet the standards established by the Department of Health and Human Services and the South Carolina Commission on Alcohol and Drug Abuse.

Children's Rehabilitative Services:

Children's Rehabilitative Services are those services provided by licensed/credentialed providers for the purpose of ameliorating, as much as possible, developmental disabilities and/or delays, improving the child's ability to function independently, and restoring maximum function through the use of diagnostic, therapeutic, and restorative services. Children's rehabilitation services shall be provided to special needs children with physical or emotional handicaps in accordance with the child's Individualized Family Service Plan (IFSP), Individualized Treatment Plan (ITP), or Individualized Education Plan (IEP). The following services are included as Children's Rehabilitative Services:

Physical Therapy Services: evaluation and treatment services provided as prescribed by a physician or other Licensed Practitioner of the Healing Arts in order to (a) preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength and muscle tone, and (b) prevent progressive disabilities through the use of orthotic and prosthetic devices, assistive and adaptive equipment, positioning, behavior adaptation and sensory stimulation.

Occupational Therapy Services: evaluation and treatment services provided as prescribed by a physician or other Licensed Practitioner of the Healing Arts in order to preserve and improve abilities for independent functioning. Service components include therapeutic exercise, neuromuscular re-education, development of the treatment plan to be followed at home, perceptual activities, fine motor manipulation skills and cognitive skills retraining.

Psychological Evaluation and Testing Services: evaluation of intellectual, emotional and behavioral status and any resulting distress and/or dysfunction. Service components include screening, diagnostic interview, testing and/or assessment.

Mental Health Counseling Services: therapeutic mental health services rendered in various environments by professional staff for the purpose of rehabilitation and restoration to an optimal level of functioning through the application of psychological principals, methods and procedures.

Early Intervention Services: therapeutic, training and support services provided in order to facilitate the developmental progress of children between the ages of birth through five years whose developmental patterns are atypical due to the influence of certain biological or environmental factors. These services include completion of developmental assessments, development of a treatment plan and regular home visits for the purpose of training parents/caregivers in the use of appropriate technologies to enhance the development of the child and support the family in their care of the child.

Intensive In-home Services: concentrated therapeutic mental health services rendered in-home by professional staff for the purpose of rehabilitation and restoration to an optimal level of functioning.

Children's Rehabilitative Services are provided by licensed/credentialed practitioners. These practitioners are limited to licensed physical and occupational therapists who are employed by recognized providers; doctoral level psychologists licensed according to state law in the specialty of Clinical, Counseling or School Psychology; Qualified Mental Retardation Professionals (QMRP), as defined in 42 CFR 483.430, employed by recognized providers; Local Education Agencies (LEA's) accredited by the State Department of Education; bachelor and master level professionals certified to provide early intervention services, and other counselors licensed/credentialed by the appropriate state entity and employed by an approved provider.

Coverage restrictions for services rendered by private practice physical therapists, occupational therapists and Ph.D. level psychologists are identified in other sections of the plan.

Speech/Language and Audiological Services: evaluations and treatment services in order to preserve and improve independent functioning by treating communication dysfunctions. Service components include evaluations, speech/language therapy, audiological testing and hearing aid evaluations and orientation.

REHABILITATIVE SERVICE FOR PRIMARY CARE ENHANCEMENT

A. Definition of Service - Rehabilitative Services for Primary Care Enhancement (RSPCE) are services recommended by a physician or other licensed practitioner of the healing arts which are furnished by (or under the supervision of) physicians or other practitioners of the healing arts licensed by the State, within the scope of their practice under State law, which are furnished in order to:

- reduce physical or mental disability, and
- restore an individual to their best possible functional level.

Covered RSPCE must either be: (1) required for the development and implementation of a comprehensive medical plan of care by a physician and other appropriate practitioners, or (2) medically necessary rehabilitative medical services identified in the comprehensive RSPCE medical plan which are not otherwise covered under the State plan.

B. RSPCE Plan of Care Requirement - The RSPCE medical plan of care must be designed to promote changes in behavior, improve health status, and develop healthier practices to restore and maintain the individual at the highest possible functioning level. The RSPCE must include the following components:

- assessment/evaluation of health status, individual's needs, knowledge level;
- identification of relevant health risk factors or health needs which justify the medical necessity for RSPCE;
- development/revision of a goal-oriented plan of care (in conjunction with the physician and individual) that addresses needs identified in the assessment/evaluation and which specifies the service(s) necessary to restore the patient to an optimal state of health;
- monitoring of health status, patient needs, skill level, and knowledge base/readiness; and
- counseling regarding identified risk factor(s) to achieve the goals in the medical plan of care.

C. Medical Necessity Criteria for RSPCE Rehabilitative Services - The RSPCE medical plan of care must include findings that rehabilitative services covered as RSPCE are required because of the individual's medical condition based on the following:

- failure to attain an optimal level of health within primary care delivery continuum; or
- entrance into the health care delivery continuum with an advanced degree of disease/condition as evidenced by a clinical evaluation and documentation in the medical plan of care; or
- a demonstrated pattern of non-compliance with the medical plan of care.

D. Special Conditions - In order to be covered as RSPCE, rehabilitative services must: (1) be included in the RSPCE medical plan of care; (2) be recommended by a physician or other licensed practitioner of the healing arts; (3) involve direct patient contact, and (4) be medically-oriented. RSPCE may include counseling services to build client and care giver self-sufficiency through structured, goal-oriented individual interventions. Group sessions that allow direct one-to-one interaction between the counselor and the individual recipient may also be used to provide some components of this service.

Qualifications of Providers - Providers of RSPCE are physicians, other licensed practitioners of the healing arts acting within the scope of their practice under State law, and unlicensed health professionals operating under the supervision of a licensed professional and furnishing services which are within the scope of practice of the licensed professional.

14.b Skilled Nursing facility Services for Individuals Age 65 or Older in Institutions for Mental Disease. (a) Must meet utilization control criteria for admission. (b) Must meet standards for certification of need.

Basic services and items furnished in an IMD facility that are included in the per diem rate and must not be charged to the patient include the following:

A. Nursing Services - Include all nursing services to meet the total needs of the resigned, the administration of treatments and medications as ordered by the physician, assistance with mobility (walking or wheelchair), and routine nursing supplies. Nursing supplies include, but are not limited to such items as syringes, air mattress, I.V. supplies, adhesive tape, canes, ice bags, crutches, glycerine, mouth swabs, water pitchers, bed pans, thermometers, and urinals.

B. Special Services - Including assistance by the facility social worker, participation in planned activities, physical therapy, speech therapy, occupational therapy and inhalation therapy.

C. Personal Services - Services for the comfort of the resident which include assistance with eating, dressing, toilet functions, baths, brushing teeth, washing and combing hair, shaving and other services necessary to maintain a clean, well kept personal appearance. Includes assistance with walking and wheelchair use when necessary. Diapers and under pads are provided as needed.

D. Room and Board - Includes a semi-private or ward accommodations, all meals including special diets and snacks ordered by the physician. Includes feeding residents if unable to feed themselves and tube feedings. Housekeeping services and bed and bath linens are included.

E. Safety and Treatment Equipment - Including, but not limited to the following items: standard wheelchairs, infusion equipment, bedside commode, side rails, restraint chairs (Geri-chairs), suction apparatus, walkers, crutches, canes and other equipment that is generally used by multiple residents and does not become the property of the individual resident.

F. Medications - Over-the-counter (OTC) non-legend medications are included (except for insulin). The resident may receive up to three prescriptions per month which are covered by Medicaid. If the drugs are obtained from a pharmacy which participates in the Alternate Reimbursement Methodology Plan, the resident is not required to pay for prescription drugs that meet the program guidelines even if the number of prescriptions is greater than three.

G. Medical Supplies and Oxygen - The following items are included, however, the included items are not limited to this list: oxygen, supplies used for inhalation therapy, catheters and related supplies, dressings, disposable enema equipment or other irrigation supplies, I.V. solutions, disposable instrument trays, levine tubes, and other supplies ordered by a physician or necessary to meet the needs of the resident because of the resident's medical condition.

15. INTERMEDIATE CARE FACILITY FOR MENTAL RETARDATION SERVICES. Prior approval for admission (or upon request for payment) is required. The Department of Mental Retardation is delegated the responsibility for level of care determination and prior approval for admission.

Basic services and items furnished in an ICF/MR facility that are included in the per diem rate and must not be charged to the resident include the following:

A. Nursing Services - Includes all nursing services to meet the total needs of the resident, the administration of treatments and medications as ordered by the physician, assistance with mobility (walking or wheelchair), and routine nursing supplies. Nursing supplies include, but are not limited to such items as syringes, air mattresses, I.V. supplies, adhesive tape, canes, ice bags, crutches, glycerine, mouth swabs, water pitchers, bed pans, thermometers and urinals.

B. Special Services - Including assistance by the facility social workers, participation in planned activities and therapeutic recreation, dental services, psychological services, physical therapy, speech therapy and hearing services, occupational therapy and inhalation therapy.

C. Personal Services - Training and assistance with eating, dressing, toilet functions, baths, brushing teeth, washing and combing hair, shaving and other services necessary to maintain a clean, well kept personal appearance. Includes assistance with walking and wheelchair use when necessary. Diapers and underpads are provided as needed.

D. Room and Board - Includes a semiprivate or ward accommodations, all meals including special diets and snacks ordered by the physician. Includes feeding residents if unable to feed themselves and tube feedings. Housekeeping services and bed and bath linens are included.

E. Safety and Treatment Equipment - Including, but not limited to the following items: standard wheelchairs, infusion equipment, bedside commode, side rails, restraint chairs (Geri-chairs), suction apparatus, walkers, crutches, canes and other equipment that is generally used by multiple residents and does not become the property of the individual resident. Also included are eyeglasses, hearing aids and other prosthetic or adaptive equipment as needed. Maintenance in good repair of dentures, eyeglasses, hearing aids, braces and other aids prescribed by appropriate specialists.

F. Medications - Over-the-counter (OTC) non-legend medications are included (except for insulin). The resident may receive up to three prescriptions per month which are covered by Medicaid. If the drugs are obtained from a pharmacy which participates in the Alternative Reimbursement Methodology Plan, the resident is not required to pay for prescription drugs that meet the program guidelines even if the number of prescriptions is greater than three.

G. Medical Supplies and Oxygen - The following items are included, however, the included items are not limited to this list: oxygen, supplies used for the inhalation therapy, catheters and related supplies, dressings, disposable enema equipment or other irrigation supplies, I.V. solutions, disposable instrument trays, levine tubes, and other supplies ordered by a physician or necessary to meet the needs of the resident because of the resident's medical condition.

H. Transportation services are required to provide other services, including vehicles with lifts or adaptive equipment as needed.

16.a Inpatient Psychiatric Facility Services: All admissions will be prior approved by the Medicaid agency or its representative based on medical necessity criteria.

16.b Psychiatric Residential Treatment Facility Services: All admissions will be prior approved by the Medicaid agency or its representative based on medical necessity criteria.

17. Nurse Midwife Services - Nurse midwives are authorized to perform services within their scope of practice authorized by State law and as documented in protocol between the nurse midwife and their physician preceptor. This protocol must be submitted to DHHS as part of the enrollment process. These services are not restricted to the maternity cycle.

18. Hospice Services - Hospice services must be available for at least 210 days. Benefit periods will be structured to coincide with those specified for the Medicare Hospice program.

Within two days of the beginning of each benefit period, the Medical Director must certify that the individual's prognosis is that his or her life expectancy is six months or less if the illness runs its normal course.

Services provided by certain Medicaid providers for care not related to the terminal illness must be prior approved by the hospice provider. The Medicaid provider will contact the hospice provider indicated on the recipient's Medicaid card to obtain authorization that the service does not relate to the terminal illness and a prior authorization number to be included on that provider's claim form. The hospice prior authorization number on the claim certifies that the services provided are not related to the terminal illness or are not included in the hospice plan of care and will be reimbursed through other Medicaid benefits. If the authorization number is not included on the claim form, it will be rejected and returned to the provider. Services that require prior authorization are:

Hospital, Pharmacy, Audiology, Psychologist Services, Speech Therapy, Occupational Therapy, Ambulatory Surgery Clinics, Medical Rehabilitation Services, School Based services, Physical Therapy, Private Duty Nursing, Podiatry, Health Clinics, County Health Departments, Home Health, Home and Community Based Services, Durable Medical Equipment, and Mental Health, Drug, Alcohol and Substance Abuse Services.

19. CASE MANAGEMENT - (MENTAL RETARDATION)

Under the authority of Section 1915 (g)(1) of the Social Security Act, Case Management Services will be covered without regard to the requirements of Section 1902 (a)(10)(B) of the Act and will be targeted to specific population groups.

A. Coverage is limited to non-institutionalized patients with mental retardation and related disabilities as diagnosed and determined under the criteria established by the South Carolina Department of Mental Retardation (SCDMR). This criteria establishes mental retardation as a person with an IQ of 70 or less which is accompanied by significant delays in adaptive behavior. Individuals with related disabilities have a severe, chronic disability that meets all of the following conditions:

(1) It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation.

(2) It is manifested before the person reaches age 22.

(3) It results in substantial functional limitations in three or more of the following areas of major life activity:

(a) Self care;
(b) Understanding and use of language;
(c) Learning;
(d) Mobility;
(e) Self-direction; and
(f) Capacity for independent living.

B. Case management for individuals with mental retardation and related disabilities is not restricted geographically, and is provided on a statewide basis in accordance with Section 1902(a)(10)(B).

C. All case management services for this targeted population are comparable in amount, duration, and scope.

D. Definition of Services:

Case management services are defined as those services necessary to coordinate an optimum life style for a targeted patient population through a coordinated effort of monitoring the patient's needs; with a systematic referral process to providers for medical, education, legal, and rehabilitative services, with documented follow-up. No counseling services will be delivered by the case manage.

Case Management services will ensure that necessary services are available and accessed for each eligible recipient.

A comprehensive Individual Needs Assessment and/or a Plan of Service will assist the case manager in providing follow-up with the patient to ensure that recommended services were accessed. A case management tracking system will be used to monitor compliance, access to services rendered, and accumulated costs.

E. Qualification of Providers:

Provider enrollment is limited to MR Programs meeting the criteria, as set forth in the "Standards for Provider Agencies Serving DMR Clients", published by the South Carolina Department of Disabilities and Special Needs (DDSN). Individual case managers assisting the patients must hold a Master's or Bachelor's degree in Social Work or a related field from an accredited university or college OR a Bachelor's degree in an unrelated field of study from an accredited university or college and have one (1) year of experience working with individuals with mental retardation or related disabilities or in a case management program. If the 1 year of experience is unrelated to working with individuals with mental retardation or related disabilities, the case manager must participate in in-service training concerning mental retardation and related disabilities. Any public or private program meeting the standards may contract with the DDSN to provide case management services.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. FREE CHOICE OF PROVIDERS

All patients eligible for Medicaid, deemed mentally retarded or an individual with related disabilities, and living in a community setting (not an intermediate care facility) will have the option of receiving case management services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services. They will have the freedom of choice to switch case managers if and when they desire.

2. Eligible recipients will have free choice of the providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to the public agencies or private entities under other program authorities for this same purpose.

19. CASE MANAGEMENT - Limitations

Under the authority of Section 1915(g)(1) of the Social Security Act, Case Management Services will be covered without regard to the requirements of Section 1902(a)(10)(B) of the Act and will be targeted to specific population groups.

A. Coverage is limited to severely emotionally disturbed children as determined by criteria established by the Continuum of Care for Emotionally Disturbed Children (CCEDC). This criteria includes the failure of other psychological or psychiatric service providers to positively impact the child. Medicaid eligible children being case managed by the CCEDC will have a history of these failures and therefore will meet the criteria for chronically mentally ill. In South Carolina severely emotionally disturbed children are considered chronically mentally ill.

B. Case management for severely emotionally disturbed children is not restricted geographically, and is provided on a statewide basis out of five (5) regional offices in accordance with Section 1902(a)(10)(B).

C. All case management services for this targeted severely emotionally disturbed children population are comparable in amount, duration and scope.

D. DEFINITION OF SERVICES:

Case management services are defined as those services necessary to assure that the targeted client has access to a full array of needed medical, educational, legal, social, treatment, and rehabilitative services. A mechanism for referral will exist as an integral aspect of this service, as will a process for follow up monitoring.

Case management for severely emotionally disturbed children will enable these children to have timely access to the services and programs that can best deal with their needs. The case managers will have small case loads which will facilitate assessment of and quick response to situations which need immediate attention.

All services will be appropriately documented in the clients case management file. Plan of care updates will occur periodically to assure that needed services are accessed.

E. Qualification of Providers:

Provider enrollment is limited to the Continuum of Care for Emotionally Disturbed Children (CCEDC) which is an agency of the State of South Carolina. Because of the severity of the emotional disturbance present in these children and their history of unresponsiveness to other agencies and providers, CCEDC is the only provider in South Carolina qualified to case manage this population.

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Individual case managers serving this population must, at a minimum, hold a Master's degree in social work, psychology, counseling, special education or in a closely related field; or a Bachelor's degree in social work or child welfare; or a Bachelor's degree in psychology, counseling, special education or in a closely related field and have at least one (1)year of experience performing clinical or case work activities; or a Bachelor's degree in an unrelated field of study and have at least three (3) years of experience performing clinical or case work activities; or a Registered Nurse licensed to practice nursing in the State of South Carolina and at least three (3) years of experience performing clinical or case work activities.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. FREE CHOICE OF PROVIDERS

All children under age 21 and eligible for Medicaid and deemed severely emotionally disturbed will be eligible to receive these case management services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.

2. Eligible recipients will have free choice of providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times

G. Payment for case management services under the plan does not duplicate payments made to the public agencies or private entities under other program authorities for this same purpose.